Behavioral Changes/Healthy Lifestyle Changes

- Assess key psychosocial factors as part of the medical management of diabetes, including attitudes about diabetes diagnosis, expectations for care, affect/mood, quality of life, financial, social, and emotional support and resources, and psychiatric history.
- Patients should be screened for psychosocial problems such as depression, eating disorders, and cognitive impairment when poor adherence to medical regime is noted.
- Set realistic goals through collaboration with the patient.
- Identify community supports and make appropriate referrals

What does psychology have to do with diabetes care?

One of the biggest struggles for both patients and practitioners is identifying, addressing, and accomplishing the behavioral changes necessary to achieve the best possible diabetes management in their daily lives. Best medical practice requires practitioners to incorporate both the "science" and "art" of behavior change. There is a wealth of research in the behavioral science literature on factors that lead to best outcomes in diabetes management.

Diabetes interventions are predominantly "behavioral." The delivery of successful medical care for individuals with diabetes ultimately depends on their ability to "self-manage." Over time, the behavioral science literature reviews and position statements have consistently shown that:

- People of all ages have difficulty following diabetes regimens.
- People can do well with some aspects of their care while having extreme difficulty with other aspects.
- Children and adults living with diabetes have the most difficulty with the following, in order:
    1. Diet
    2. Exercise
- Timing and adjustment of diabetes medications is difficult and can result in adherence issues.
- Miscommunication between patients and providers on important aspects of diabetes care is an ongoing issue.

What are the key psychosocial factors affecting chronic care?

Best practice looks at assessing the "whole person" to assess where potential strengths and weaknesses with the diabetes regime are likely to occur. Assessment should include, but is not limited to, the following areas:

In child and adolescent patients:

- Developmental stage
- Temperament
- Parent-child issues
- Family dynamics
- Extended family/support
- Cognitive/school issues
- Psychiatric history (patient, family)
- Substance use/abuse
- Cultural issues

- Overall “quality of life”
- Weight history/genetics
- Coping skills

In adult patients:

- Personality
- Natural/acquired coping skills/style
- Role of significant others (helpful, hurtful)
- Role of family of origin
- Diabetes at work and play
- Psychological factors/predictors of poor adjustment
- Psychiatric history (patient, family)
- Substance use/abuse
- Cultural issues
- Overall “quality of life”
- Weight history/genetics

Treatment issues across the ages.

- Depression is more common among people with diabetes than it is in the general public
    1. may be more severe for people with diabetes
    2. has an adverse effect on diabetes control and self-care
    3. is often undiagnosed and untreated
    4. can be treated with psychotherapy and/or psychopharmological agents
- Anxiety
    1. appears to be more prevalent in people with diabetes than the general population
    2. can be treated with psychotherapy and/or psychopharmological agents
- Eating disorders (anorexia nervosa and bulimia nervosa)
    1. appear to be more common in people with diabetes than the general public
    2. may be more severe for people with diabetes
    3. have an adverse effect on diabetes control
- Setting realistic goals: Collaboration is key
- Diabetes team issues: When practitioners disagree on care
- Team-family collaboration/conflict
- Struggles with adherence
- Meal planning
- Exercise
- Peer issues
- Provider and patient burnout
- Economic issues
- Cultural factors

What behavioral strategies enhance diabetes management?

- Adopt an educational model of patients as “continuous learners.”
- Individualize treatment to fit strengths/weakness of patient/family, including assessing individual patient “coping style.”
- Incorporate “empowerment” approaches to enhance patient’s “self-efficacy” (i.e., patient successfully targeting and accomplishing a particular goal).

- Motivational interviewing (MI) is a technique that assists the patient in identifying feelings of ambivalence that exist when working to change a behavior. MI relies on the patient's own inner strength and values rather than external threats and coercion. The patient assumes responsibility for their choices and the subsequent consequences (Rollnick and Miller, 2001).
- Assess readiness for behavior change:
    1. Precontemplation – not thinking about change
    2. Contemplation – considering change in the foreseeable future
    3. Preparation – seriously considering change in the near future
    4. Action – in the process of change
    5. Maintenance – continued change for an extended period
- Verbally reinforce positive behaviors.
- Avoid "punishing" and/or "shaming" patients for diabetes mismanagement. Arrange for other provider care when a bad 'fit' between patient and provider exists.
- Practice a "problem solving" approach and teach patient and family members this as a strategy.
- Practice good communication skills and advocate the same for communication between patient and family members.
- Assess and enhance community supports (medical, school, work, social, religious) including, but not limited to, formal support groups specific to diabetes patients and families.
- Identify and intervene with depression and other mental health risk behaviors early.

References:

1. Anderson, B.J. & Rubin, R.R. (2002). Practical Psychology for Diabetes Clinicians: Effective techniques for key behavioral issues (2nd ed.). Alexandria, VA: American Diabetes Association.
2. Anderson, R.M. & Funnell, M.M. (2000). Compliance and adherence are dysfunctional concepts in diabetes care. Diabetes Educator, 26, 597–604.
3. American Association of Diabetes Educators. (2006). The art and science of diabetes self-management education: A desk reference for healthcare professionals. Chicago, IL: American Association of Diabetes Educators.
4. American Diabetes Association. (2007). Standards of medical care in diabetes. Diabetes Care, 30(Supplement 1), S4-S41.
5. Glasgow, R.E. et al (1999) Behavioral Science in Diabetes: Contributions and opportunities. *Diabetes Care*, *22*, 832-843.
6. Rollnick, S. & Miller, W. (2001). Motivational interviewing: What is MI? Accessed on December 21, 2007, from http://www/motivationalinterview.org/clinical/whatismi.html.